Overview of HIPAA-Mandated Transactions:
Billing, Coding and Policy Changes...

Michigan Department of Community Health

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Introduction to Electronic Data Interchange (EDI)

What is EDI?

- ◆ System for arranging data so that a computer can read it without human intervention.
- ◆ Automated trading of information can streamline the existing process to the benefit of both parties.
- ◆ National standards for EDI were developed to avoid difficulties and expenses incurred if proprietary formats were used.
- ◆ Also used as a substitute for other types of data exchange:
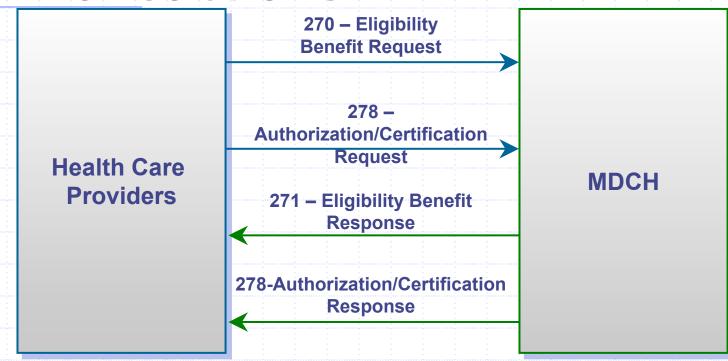 - Phone calls
  - Fax
  - Face-to-face discussions

Benefits of EDI

◆ General benefits of using EDI are derived from the use of computer processing and information networks to streamline and enhance business activities conducted with external parties.

  ■ The benefits of EDI include:
    ◆ Decreased administrative expense
    ◆ Faster payment
    ◆ Reduced data-entry errors
    ◆ Fewer re-bills
    ◆ Easier remittance posting
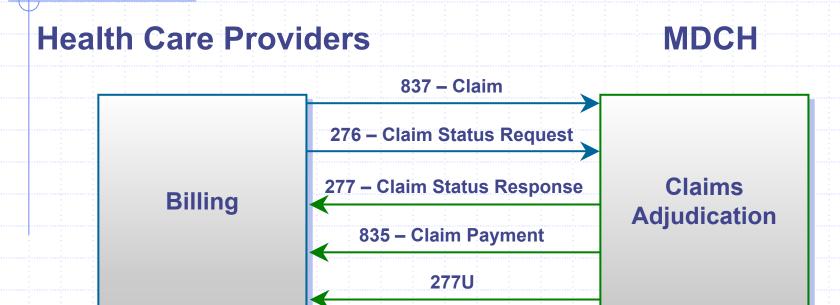   ◆ Additional service offerings
    ◆ More efficient utilization of staff

HIPAA-Mandated Transactions

◆ The following are HIPAA-mandated transactions:

- 837: Health Care Claims and Equivalent Encounter Information
- 835: Health Care Payment and Remittance Advice
- 276/277: Health Care Claim Status
- 270/271: Eligibility Query and Response
- 834: Enrollment and Disenrollment in a Health Plan
- 820: Premium Payments
- 278: Referral Certification and Authorization

Prior to Treatment Transactions

Health Care Providers

270 – Eligibility Benefit Request →

278 – Authorization/Certification Request →

271 – Eligibility Benefit Response ←

278-Authorization/Certification Response ←

MDCH

Claim-Related Transactions

Health Care Providers   **MDCH**

837 – Claim

276 – Claim Status Request

277 – Claim Status Response

835 – Claim Payment

277U

Billing

Claims Adjudication

270/271 Eligibility Benefit Inquiry and Response

270/271 Overview

- ◆ The 270 is used by a provider to request eligibility, coverage, and benefit information from a payer.

- ◆ The 271 is used by the payer to respond to a provider's request for eligibility, coverage, and benefit information.

MDCH Eligibility Verification System

◆ MDCH currently contracts with outside entities to manage eligibility verification on behalf of the Department.

◆ MDCH provides these contractors with eligibility files and updates on a 6-month, weekly or daily schedule.

◆ Eligibility files contain information for all Programs and also include: Provider file, Managed Care Provider file, Other Insurance Coverage file and MDCH Carrier file.

MDCH Eligibility Verification System (continued)

◆ Eligibility verification from MDCH contractors through a variety of products, including:

- Automated Voice Response System with Voice or Fax Back Response

- Electronic Data Interchange (EDI): PC-Based, Browser-Based, and Point of Service (POS) Eligibility Verification System (EVS)

270/271 Testing Information

- Medifax EDI
- Contact Medifax directly to test the X12 transaction
- X12 has not yet been approved; transaction formats could change

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278 Authorization/Certification Request and Response

278 Overview

◆ A 278 can be used to:

- Request an authorization.
- Request approval for referral to another provider. (Not applicable to MDCH).
- Respond to incoming requests.

◆ A 278 Transaction:

- A 278 may not always include the necessary information to make a determination. In such cases, additional information will be provided through paper submissions or 275 attachment transactions.

Note: The 278 transaction is still an evolving transaction

837 Healthcare Claim

The 837 Transaction

◆ The HIPAA-mandated transaction to be used for electronic transfer of health care claims or equivalent encounter information is the ASC X12N 837 Health Care Claim, Version 4010A1.

- Professional
- Institutional
- Dental

Interactions with Other Transactions

◆ Providers can supply certain information on the claim in order to match it with the Remittance Advice.

◆ If this information is supplied in the 837 transaction, it must be echoed on the 835 Remittance Advice.

Includes:

- Patient Control Number
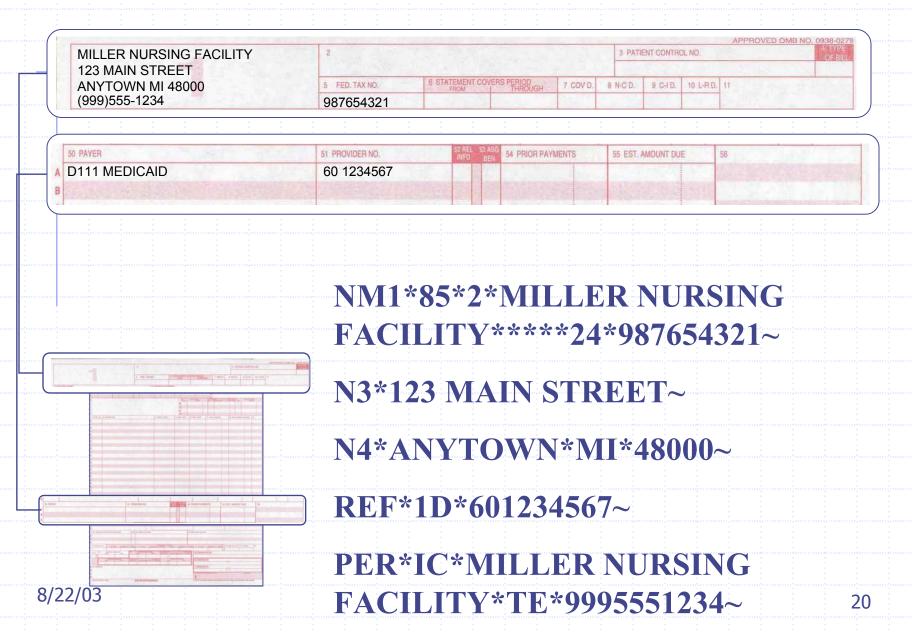- Patient Account Number
- Medical Record Number

Data Overview

◆ Six important types of information contained in the 837 transaction:

- Submitter/Receiver

- Provider

- Subscriber/Patient

- Claim

- Service Line
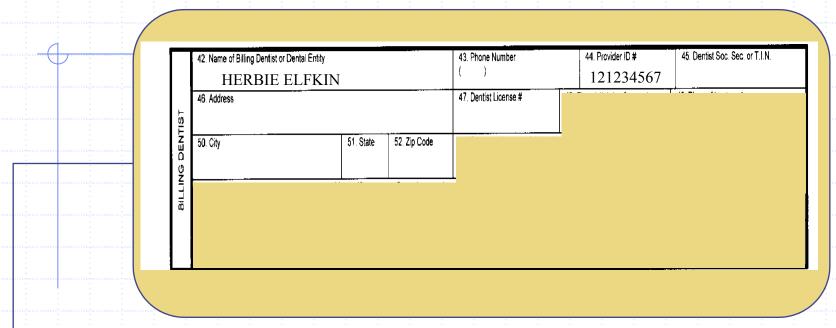
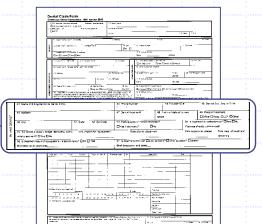- Coordination of Benefits (COB)

Billing Provider - Professional

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
987654321	X		☐ YES ☐ NO	$	$	$

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Margaret Sanger SIGNED DATE	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # MARGARET SANGER MD 456 DOCTORS WAY BIG CITY MI 48765 2488471212 PIN# 101234567 GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)   PLEASE PRINT OR TYPE   APPROVED OMB-0938-0008 FORM HCFA-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

NM1*85*1*SANGER*MARGARET**34*987654321~**

N3*456 DOCTORS WAY~

N4*BIG CITY*MI*48765~

REF*1D*101234567~

PER*ICTE*2488471212~**

Billing Provider - Institutional

						APPROVED OMB NO. 0938-0279
MILLER NURSING FACILITY 123 MAIN STREET ANYTOWN MI 48000 (999)555-1234	2			3 PATIENT CONTROL NO.		4 TYPE OF BILL
	5 FED. TAX NO. 987654321	6 STATEMENT COVERS PERIOD FROM THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	D111 MEDICAID	60 1234567					
B							

NM1*85*2*MILLER NURSING FACILITY*****24*987654321~

N3*123 MAIN STREET~

N4*ANYTOWN*MI*48000~

REF*1D*601234567~

PER*IC*MILLER NURSING FACILITY*TE*9995551234~

8/22/03

20

Billing Provider - Dental

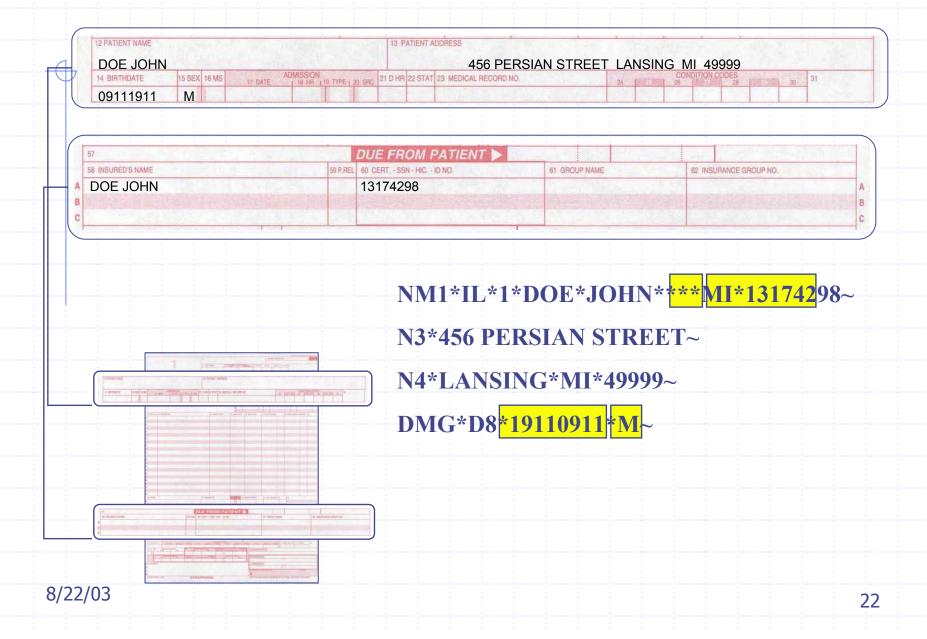| 42. Name of Billing Dentist or Dental Entity	43. Phone Number	44. Provider ID #	45. Dentist Soc. Sec. or T.I.N.
HERBIE ELFKIN	( )	121234567	
46. Address		47. Dentist License #	
50. City	51. State	52. Zip Code	

NM1*85*1*ELFKIN*HERBIE****34*456789123~

N3*123 MAIN~
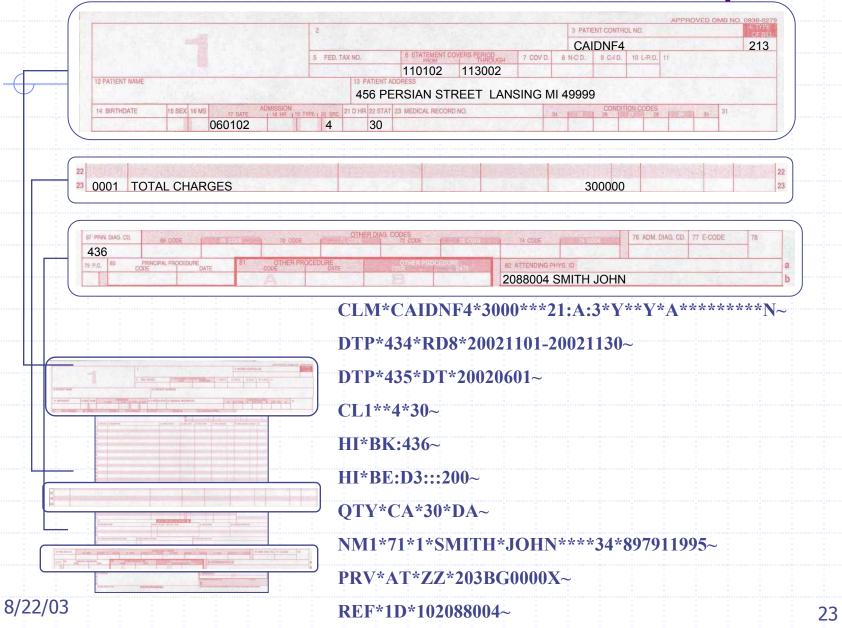
N4*NORTH POLE*MI*48122~

REF*1D*121234567~
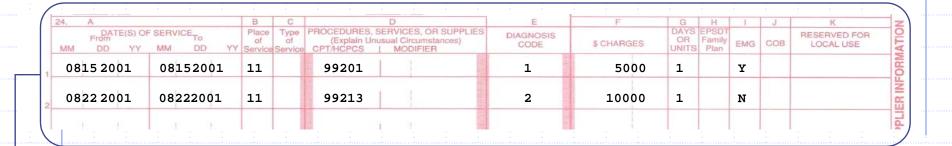
Subscriber/Patient Information Example

NM1*IL*1*DOE*JOHN****MI*13174298~

N3*456 PERSIAN STREET~

N4*LANSING*MI*49999~

DMG*D8*19110911*M~

Claim Level Information Example

CLM*CAIDNF4*3000***21:A:3*Y**Y*A*********N~

DTP*434*RD8*20021101-20021130~

DTP*435*DT*20020601~

CL1**4*30~

HI*BK:436~

HI*BE:D3:::200~

QTY*CA*30*DA~

NM1*71*1*SMITH*JOHN****34*897911995~

PRV*AT*ZZ*203BG0000X~

REF*1D*102088004~

Service Line - Professional

24.	A					B	C	D		E	F	G	H	I	J	K	
	DATE(S) OF SERVICE					Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		DIAGNOSIS CODE	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE	
	From			To				CPT/HCPCS	MODIFIER								
	MM	DD	YY	MM	DD	YY											
1	0815	2001		0815	2001		11		99201		1	5000	1		Y		
2	0822	2001		0822	2001		11		99213		2	10000	1		N		
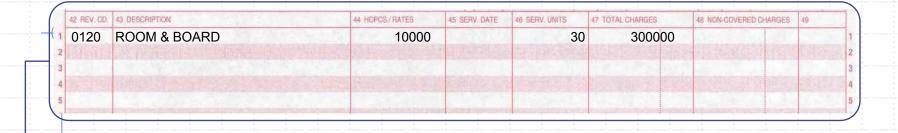
LX*1~
SV1*HC:99201*50*UN*1*11**1**Y~
DTP*472*RD8*20010815-20010815~
LX*2~
SV1*HC:99213*100*UN*1*11**2**N~
DTP*472*RD8*20010822-20010822~
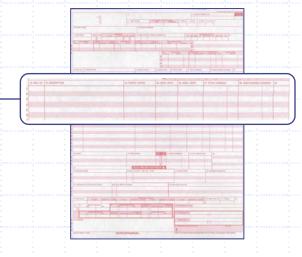
Service Line - Institutional

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0120	ROOM & BOARD	10000		30	300000		

Example 1:

LX*1~

SV2*01203000*DA*30*100~**
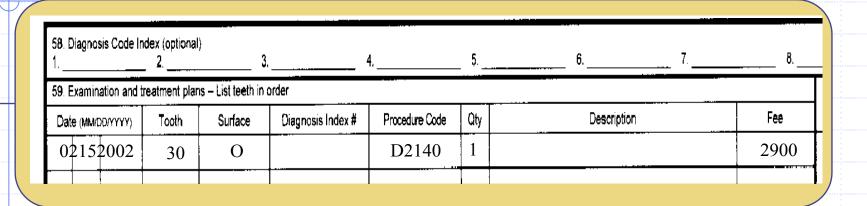
Example 2:

LX*1~

SV2*0420*HC:97016*100*UN*2~

Service Line - Dental

58. Diagnosis Code Index (optional)

1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____

59. Examination and treatment plans – List teeth in order

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee
02152002	30	O		D2140	1		2900

```
LX*1~

SV3*AD:D2140*29****1~

TOO*JP*30*O~
```

276/277 Healthcare Claim Status Request and Response

276/277 Overview

◆ Purpose of the 276/277 transactions is to give providers an electronic means to ask for the processing status of:

- Professional claims
- Institutional claims
- Dental claims

276/277 Overview

- The following data elements are being utilized by MDCH as search criteria:
  - Provider ID (MDCH assigned type code and provider ID for the billing provider)
  - Subscriber (beneficiary) ID
  - Payer's Claim Number (Claim Reference Number – CRN)
  - Date of Service (cannot contain a date range of more than 31 days)

276/277 Overview (continued)

- ◆ A claim level or service (line) level status may be submitted.

- ◆ 276 Request transactions are processed in a weekly batch.

  - ■ Accepted for processing between Wednesday and Tuesday will result in corresponding 277 Response transaction the following Tuesday evening.

  Note: The CRN is optional and when not included in the request, the submitted date of service or dates of service range will be used in conjunction with the provider ID and Subscriber ID to locate the claim(s)

U277 Unsolicited Claim Status

U277 Overview

- ◆ MDCH has chosen to implement the U277 as a means of communicating pended claim information.
- ◆ U277 is not a HIPAA-mandated transaction.
- ◆ U277 is available to Medicaid providers on request through their billing agent.

U277 Overview (continued)

- U277 is sent on the same cycle as the 835 and paper RA.

- U277 will be generated for everyone who requests an 835.

- Both electronic and paper claims will be reported on the U277.

Introduction to the 835 –Health Care Claim Payment & Remittance Advice

835 Overview

◆ HIPAA-mandated standard transaction.

◆ Used to transfer payment and remittance information for adjudicated dental, professional, and institutional health care claims.

◆ Only Paid and Denied claims can be reported in an 835 transaction using claim status codes.

◆ Pended information is transmitted via a U277 Unsolicited Claim Status.

835 Overview

◆ Contains information about:

- The payee (providers and/or their agents).

- The payer

- Amount

- Any identifying information regarding the payment

- Detailed payment information including, if applicable, reasons why the total original charges were not paid in full.

Relationship to Payment Device

- One 835 transaction corresponds to one payment device and one payee.

- Payment is sent from MDCH to a payee via check or EFT.

- The entity receiving the payment is defined as the payee.

- A unique trace number that corresponds to the check or EFT is assigned by MDCH for reassociation.

Features Not Included in the 835

- Diagnosis codes

- Tooth Surface and Tooth Number

- Proprietary codes/edit codes

- Fund code information

- Reporting of pended claims

- No message page

Advantages

◆ Serves as an input to the provider's billing and accounting systems.

- The 835 transaction is designed to allow easier posting and reconciliation of remittance information

- It includes a trace number to identify the warrant or electronic funds transfer (EFT) payment

- The provider's internal Medical Record Number, Line Item Control Number, and Patient Control Number will be returned when submitted on the original claim

Standard Claim Adjustment Codes

♦ Each proprietary code has been cross-walked to standard claim adjustment codes:

- **Claim Adjustment Group Codes -** Identify the general category of the payment adjustment

- **Claim Adjustment Reason Codes -** Communicate why a claim or service line was paid differently than it was billed

- **Remark Codes –** Used to relay service-specific informational messages that cannot be expressed with a reason code

♦ Standard claim adjustment codes will be transmitted on the paper RA.

Standard Adjustment Reason Codes

◆ Used when making non-claim specific adjustments (i.e. provider).

◆ Describes the reason why the payment was increased or decreased.

◆ Similar to MDCH Gross Adjustment (GA) Code.

◆ MDCH codes have been cross-walked to the standard codes.

www.wpc-edi.com/organization_40.asp

Paper Remittance Advice (RA)

Changes to the Paper RA

- ◆ Standard codes will replace proprietary codes:
  - Claim adjustment group, reason and remark codes
  - Provider adjustment codes
  - Claim status codes
- ◆ The following will no longer be reported:
  - Diagnosis codes
  - Tooth Surface and Tooth Number
  - Proprietary codes/edit codes
  - Fund code information
  - Pended claims

Companion Documents

Companion Documents

◆ Data clarification documents were created by MDCH as a companion to the National Electronic Data Interchange Transaction Set Implementation Guides.

◆ Data Clarification Documents can be found on the MDCH web site: www.michigan.gov/mdch

Primary Resources

Michigan Department of Community Health:

◆ Web Resources:

■ Official Policy and Information: www.michigan.gov/mdch

◆ Click on Provider, then HIPAA, and then HIPAA Implementation Materials.

■ Medicaid Informational Letter, July 2003: http://www.michigan.gov/documents/L03-23_July_HIPAA_Letter_70365_7.pdf

■ Business-to-Business (B2B) Test Instructions: http://www.michigan.gov/documents/B2B_Testing_Instructions_MV_Feb_10_03_pdflinks_57409_7.pdf

■ Electronic Submission Manual: http://www.michigan.gov/documents/MDCHElectronicSubmissionManual10-04-2002_51617_7.pdf

Primary Resources

- MDCH's HIPAA Primer Course:
  - Michigan Virtual University (MIVU): www.healthcare.mivu.org

- Contact Information:
  - Provider Support Email: providersupport@michigan.gov
  - Provider Support Hotline: 1 (800) 292-2550
    - Billing and Policy Information.
  - To Become an Authorized E-Biller: automatedbilling@michigan.gov

Question and Answer Session